



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-0472-01
SICEM 12626 Blanco Rd #2204 San Antonio, TX 78216	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
TX Mutual Insurance Company, Box 54	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "The reasons for denial of payments are invalid. The requestor provided effective, highly efficient and necessary treatment within all parameters established by DWC guidelines to address the compensable injuries sustained by the injured worker. Therefore, full payment for our claims is warranted."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Texas Mutual requests that the request for dispute resolution filed by SICEM be conducted under the provisions of the APA set out above."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
5-11-04 – 11-1-04	CPT codes 97112 (\$32.08 X 56 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,796.48
5-11-04 – 11-1-04	CPT code 97113 (\$33.67 X 17 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$572.39
5-11-04 – 11-1-04	CPT code 97140 (28.82 X 56 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,613.92
5-11-04 – 11-1-04	CPT code 97110 (\$30.92 X 28 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$8,657.60
5-11-04 – 11-1-04	CPT code 97150 (\$20.62 X 40 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$824.80
5-11-04 – 11-1-04	CPT code 97750-FC (\$30.09 X 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$60.18
			\$13,525.37

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor did prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$13,525.37.

Based on review of the disputed issues within the request, the Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 11-29-05 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Regarding CPT codes 97545-WC and 97546-WC on 10-11-04, 10-12-04, 10-13-04 and 10-14-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Per Rule 134.202 (e) (5) (B) (ii) reimbursement is \$36.00 per hour. These services were preauthorized by the insurance carrier in letters dated 9-28-04 and 10-26-04. Recommend reimbursement of \$1,152.00.

Regarding CPT codes 97545-WC and 97546-WC on 10-15-04, 10-18-04, 10-19-04, 10-20-04, 10-21-04, 10-25-04, 10-26-04, and 11-1-04: "320 - nonaccredited interdisciplinary program. Payment reduced 20% below MAR or below usual and customary." Per Rule 134.202 (e) (5) (B) (ii) reimbursement is \$36.00 per hour. The carrier has reimbursed \$1,321.92. Recommend additional reimbursement of \$737.28.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307 (e)(2)(B), 133.308, 134.202(c)(1), 134.202 (e) (5) (A) (ii).

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the carrier must refund the amount of the IRO fee (\$650.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to reimbursement in the amount of \$15,414.65. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision by:

1-25-06

Order by:

1-25-06

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.